New Hampshire Department of Health and Human Services (DHHS)
Division of Community Based Care Services (DCBCS)
Bureau of Drug and Alcohol Services (BDAS)

Impaired Driver Care Management Program (IDCMP)
APPLICATION INSTRUCTIONS

General Instructions

Pursuant to He-A 503.01, no provider, institution, organization, corporation, person, partnership, firm, or organization, whether public or private, shall offer, advertise, deliver, or provide services that are within the scope of He-A 500 without first submitting an application and obtaining approval from the commissioner.

An application shall be complete when the Department determines that all items required by He-A 503.02(a) have been received. The Department shall notify the applicant in writing of the missing items required before the application can be processed. After written notice and failure to provide missing information, an incomplete application shall not be processed.

Applicants shall be notified within 90 days of receipt of a complete application as to the status of their application. The Commissioner's approval of an IDCMP application shall be based upon the applicant's ability to offer programs and services in accordance with the Administrative Rules, as evidenced by responses to the specific requirements of this application.

By submitting an application, an applicant agrees to allow the Department to verify or validate any information supplied or to ask any questions of the applicant about an application. Misinformation in an application may be a basis for denial.

Applicants shall be an approved Access to Recovery (ATR) provider and actively enroll clients in the ATR program. Applicants must agree to attend BDAS sponsored training sessions and utilize the Web Information Technology System (WITS) modified electronic client record software.

Applicants will not receive funding from the State of New Hampshire. Programs are to be financially self-sustained from client fees.

Successful applicants will be held accountable for meeting all program requirements under He-A 500 and maintain records of activities related to IDCMP. Such records shall be made available to DHHS upon request, or within a reasonable time, during normal business hours.

All applications become the property of the State of New Hampshire and will be a matter of public record. Business financial information and proprietary information such as trade secrets, business and financials models and forecasts, and proprietary formulas may be exempt from public disclosure under RSA 91-A:5, IV. If you believe any information being submitted in response to this application should be kept confidential as financial or proprietary information, you must specifically identify that information.

How to Apply

Submit an original typewritten application and the required attachments as specified in Addendum #1. Applications shall be no less than 11-point font, and the pages shall be numbered. All acronyms shall be spelled out the first time that they are used. All submissions must be accompanied by an electronic version on a flash drive or compact disc. Do not e-mail completed applications.

A fill-in version of the application may be obtained on the Bureau's website by accessing http://www.dhhs.nh.gov/dcbcs/bdas/driving.htm. Retain a copy of the completed application and attachments for your records.

When & Where to Apply

Prior to commencing IDCMP services, organizations shall obtain approval from DHHS through the application process contained in the document and promulgated in He-A 500. An initial approval shall be valid for a one-year period following approval. Requests for continued approval beyond the initial one-year period shall be submitted to the Department at least 90 days prior to the expiration of the current approval pursuant to He-A 503.02(a).

Application and required supporting documentation shall be submitted to the following address:

NH Bureau of Drug and Alcohol Services
Clinical Services Unit – IDCMP Coordinator
3rd Floor North
105 Pleasant Street
Concord, NH 03301

Application Approval Process

Each application will be individually reviewed by Department staff. The review will be focused on proper completion of all elements of the application and applicant statements demonstrating compliance to He-A 500 rules. The commissioner of DHHS will make the final approval determination. Applicants shall be notified within 90 days of receipt of a complete application as to the status of their application.

Initial approvals will be for one year. Renewals may be granted for an additional three years, subject to DHHS approval.

Questions

Inquiries relating to the Impaired Driver Care Management Program, application status, or other related issues may be submitted to the address above or by telephone at 603-271-6107 between the hours of 8:00 am and 3:00 pm.

Line-By-Line Instructions

1. Indicate the application type by placing a check in the appropriate box. If a renewal request, enter the expiration date of the current approval.
2. Enter the applicant organization's legal name.
3. Enter the applicant organization's federal identification number.
4. Enter the name and title of the organization's director, sole member, or primary member.
5. Enter the physical address of the organization's facility where services will be offered.
6. Enter the mailing address (if different than the physical address in 5).
7. Enter the hours of operation [pursuant to He-A 504.04(a)-(b)].
8. Enter the main telephone number for the location listed in 5 above.
9. Enter the fax number for the location listed in 5 above.
10. Enter the name and telephone number of the person to be contacted for any questions relating to this application.
11. Enter the primary contact person's e-mail address.
12. For each additional site where services are offered, enter the physical address, telephone number, hours of operation, and services provided.
13. Place a check in the appropriate box to indicate the educational programs you will provide.
14. List your monthly educational cycle schedule, based on options listed in He-A 508.02.
15. Check all that applies to the organization & facility accessibility options.
16. Enter a brief statement describing the organization's accessibility options available.
17. Enter a brief statement to describe the organization's funding sources and any anticipated changes in the next 12 months. Attach a separate narrative if additional space is needed.
18. Provide a narrative to describe significant changes to the organization/program in the last year or anticipated in the next 12 months.
19. Describe the organization's client confidentiality policies and procedures.
20. Describe the organization's experience in providing impaired driver services at least comparable to an IDCMP and an impaired driver education program (IDEP).
21. If your agency has breached an agreement or a contract with DHHS within the past 3 years, describe the circumstances of the situation.
22. Check the organizational structure that applies. Non-profits – enter the Internal Revenue Code Exemption section. For-profits – enter the organization type, e.g. Corporation, Sub-chapter S Corporation, Partnership, Proprietorship, LLC.
23. Check all that apply with regard to the organization's information system availability.
24. Applications must be dated and signed in ink by the organization's officer, program director and/or applicant representative. Print name and title of all signatories.

New Hampshire Department of Health and Human Services (DHHS)
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Impaired Driver Care Management Program (IDCMP) Application

Applicant Information:	
1. Application Type: ☐ Initial ☐ Renewal (Exp. date of current approval: _____)	
2. Organization name:	3. Tax ID Number:
4. Name and title of organization's director:	5. Physical address (primary location):
6. Mailing address:	7. Hours of operation:
8. Phone number:	9. Fax number:
10. Primary contact person:	Primary contact phone number:
11. E-mail address:	
12. Additional site information (physical address, telephone number, hours of operation, services provided).	
Education Program Information	
13. Check one or both of the educational programs you wish to provide. ☐ **IDEP** Impaired Driver Education Program ☐ **WIDEP** Weekend Impaired Driver Education Program	
14. What is your monthly IDEP uniform session education cycle schedule? Check all that apply ☐ **4, 5 or 6 sessions (circle appropriate #)** ☐ **4 sessions on 2 consecutive weekends - on both Saturdays & Sundays** ☐ **4 sessions on 2 consecutive weekends –on both Fridays & Saturday** ☐ **3 sessions on 3 consecutive Saturdays or Sundays** ☐ **3 sessions on 2 consecutive weekends (sessions on Saturday & Sunday of one weekend and either Saturday or Sunday the following weekend)**	
Facility and Program Information	
15. Organization & facility accessibility: (Check all that apply) ☐ Is located within 1 mile of public transportation ☐ Offers American Sign Language interpretation ☐ Offers services in languages other than English If so, which language(s)? ☐ Has separate male and female sleeping, showering, and bathroom areas (for WIDEP) ☐ Entire building is handicap accessible ☐ If not entirely accessible, describe accessibility	
16. Describe your site location(s) and client accessibility to your location(s). Include accessibility to public transportation, accessibility for individuals that do not have a driver's license, etc. (Attach narrative if additional space is needed.)	

17. Describe your organization's funding sources in addition to client fees. (Attach a separate narrative if additional space is needed.)
18. Describe significant changes in your organization and those pertinent to the program which occurred during the current fiscal year or which are planned for the upcoming 12-month period (for example, changes in geographic area, staffing, or reorganization of agency structure). (Attach a separate narrative if additional space is needed.)
19. Confidentiality. Describe the organization's client confidentiality policies and procedures to comply with 42 CFR Part 2. (Attach a separate narrative if additional space is needed.)
20. Pertinent experience. Describe your organization's experience <u>in providing impaired driver services at least comparable to an IDCMP and an IDEP</u>.
21. DHHS agreement/contract. In the past three years have you or your organization breached an agreement or a contract with DHHS. If yes, explain.

Type of Organization:
22. Please indicate organizational type (select all that apply): ☐ Non-profit – Internal Revenue Code Exemption Section ☐ For-profit – Organization type:

Information System Requirements:
23. Check all that apply to your organization/facility: ☐ Organization utilizes Windows Internet Explorer 7.0 or higher ☐ Organization utilizes high speed internet access ☐ Organization utilizes WITS

Approval of an IDCMP application shall be granted to those applicants that demonstrate, in a manner satisfactory to the Commissioner of the Department of Health and Human Services, that the applicant has the professional capability, financial viability, and pertinent experience necessary to provide the services required of an IDCMP.

An application shall be complete when the Department determines that all items required by He-A 503.02(a) have been received. The Department shall notify the applicant in writing of the missing items required before the application can be processed. After written notice and failure to provide missing information, an incomplete application shall not be processed.

24. We certify the information in this application and in the supporting documentation listed in the Application Checklist is correct and true, and that we have read and understand NH Administrative Rules He-A 500, Impaired Driver Programs, and agree to comply fully if we are approved as a provider.

_____	_____	_____
Signature of Organization's Officer	Print Name & Title of Officer	Date
_____	_____	_____
Signature of Program Director	Print Name of Program Director	Date
_____	_____	_____
Signature of Applicant Representative	Print Name & Title or Position	Date

List of Addendums:
Addendum #1: Application Check List
Addendum #2 Program Staff Form (and instructions)
Addendum #3: Budget Form and Narrative

Addendum #1

IDCMP Application

Application Checklist

For an application to be considered complete, the following documents and information shall be submitted to BDAS:

☐ IDCMP Application

☐ Program Staff Lists (Addendum #2) for the current year and one for each of the next three projected years, including copies of current licenses/certificates for each licensed/certified staff member.

☐ Budgets (Addendum #3) for the current year and one for each of the next three projected years along with appropriate narratives.

☐ Certificate of Insurance for General Liability and Worker's Compensation with the NH DHHS, 105 Pleasant St., Concord, NH listed as the Certificate Holder.

☐ Certificate of Good Standing.

☐ Certificate of Vote.

☐ ATR approval letter.

☐ Current list of board of directors or governing body members, including for each member: position; address; place of employment; and contact information. Also, a schedule of board of directors meeting dates.

☐ Documentation that each service site meets the minimum applicable state and municipal Life Safety Codes and other applicable standards.

☐ Either:

☐ Most recent full year audited financial report prepared in accordance with Generally Accepted Accounting Principles, along with a copy of the most recent tax return and annual report, if applicable; or

☐ If a start-up organization, in lieu of an audited financial report, a business plan which includes the following:

(i) Executive summary that highlights the mission and vision in 2 pages or less;

(ii) Company summary that provides a factual description of the organization, ownership, and history;

(iii) Description of services to be provided and how they compare to that of competitors;

(iv) Market analysis that summarizes the client base, competitive landscape, market area, and expected market growth;

(v) Management summary that describes the background on the management team, their experiences, and key accomplishments; and

(vi) Financial plan that contains key financials including projected revenues, cash flow, and profits.

☐ Policy and procedures manual.

☐ Financial Viability Narrative. Demonstrate the organization's ability to generate sufficient income to meet operating expenses, debt commitments and where applicable, to allow growth while maintaining service levels.

☐ Evidenced-based curriculum syllabus. Provide a curriculum syllabus outlining all the components of the program and detailed descriptions of how these components fit into a typical program cycle.

Note: In order for a curriculum to be considered evidence-based, as required by RSA 265-A:39, II, and pursuant to He-A 508.04, it shall meet one of the following requirements:

(1) It shall be included in SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP);
(2) It shall have been published in a peer-reviewed journal and have been found to have positive effects; or
(3) The IDCMP or applicant shall provide documentation of the curriculum's effectiveness based on the following:

a. The curriculum is based on a theoretical perspective that has validated research; or
b. The curriculum is supported by a documented body of knowledge generated from similar or related curricula that indicate effectiveness.

Addendum #2

New Hampshire Department of Health and Human Services
DCBCS/BDAS
IDCMP Application
Program Staff List

COMPLETE AND SUBMIT ONE PROGRAM STAFF LIST FOR THE CURRENT YEAR AND ONE EACH FOR THE NEXT THREE PROJECTED YEARS

Applicant Organization Name: _____

Budget Period: _____

A	B	C	D	E	F
Position Title	**Current Individual in Position**	**Projected Hourly Rate as of 1st Day of Budget Period**	**Hours per Week**	**Total Salaries**	**Site***
Example:					
Program Coordinator	Sandra Smith	$21.00	40	$43,680	
Total Salaries by Program				$0.00	

Please note, any forms downloaded from the DHHS website will NOT calculate.
Contact DCBCS/BDAS for assistance.

*Please list which site(s) each staff member works at, if your organization has multiple sites.

Program Staff List
Instructions

This form should include all staff in the program. It should provide an accurate projection of all staff salaries to be paid for the budget period. Complete one Program Staff List for each required year. List each staff member's:

A. Position title
B. Name
C. Hourly rate as of the first day of the budget period
D. Number of hours worked per week (total)
E. Total salaries all sources

If the program has current vacant positions or projected new positions, list them as vacant in the name column and complete the remaining columns as instructed above.

If the program has more than one site:

F. List the site at which each staff member works. Do not include volunteers or consultants.

The total salaries must match the total salary/wages line item on the budget form.

Benefits are not included here. Consultants should be listed separately on line 3 of the budget form and described in the budget narrative.

Addendum #3

New Hampshire Department of Health and Human Services
DCBCS/BDAS
IDCMP Application

Budget Form

COMPLETE AND SUBMIT A BUDGET FORM FOR THE CURRENT YEAR AND ONE EACH FOR THE NEXT THREE PROJECTED YEARS	
Applicant Organization Name:	
Budget Period:	
Line Item	**Total**
1. a. Total Number of Administrative Positions	
1. b. Total Number of Instructional Positions	
1. c. Administrative Salary/Wages	$ -
1. d. Instructional Salary/Wages	$ -
1. e. Total Salary/Wages	$ -
2. Employee Benefits	$ -
3. Professional Fees/Consultants	$ -
4. Equipment/Furnishings	$ -
5. Office Supplies	$ -
6. In-State Travel	$ -
7. Occupancy/Rent/Utilities	$ -
8. Current Expenses	$ -
Telephone	$ -
Postage	$ -
Printing/Reproduction	$ -
Insurance	$ -
Food (for WIDEP)	$ -
9. Other (specify):	$ -
	-
	-
TOTAL	$ -
Contact DCBCS/BDAS for calculating forms.	

Budget Form
Instructions

All forms will be sent electronically to those submitting an E-mail request. Please use electronic Budget Forms, as all calculations will be done for you. The Department is not responsible for calculation errors due to modification of any forms. **Contact DCBCS/BDAS, IDCMP Coordinator for calculating forms**. *Submit Budget Forms as hardcopies with the application documents.*

Submit one budget form for the current year and one for each for the next three projected years. In addition, a budget narrative must be submitted with each budget form.

1. **a. Total Number of Administrative Positions**
   b. Total Number of Instructional Positions
   c. Administrative Salary/Wages—From the Program Staff List, include the total Administrative Salary/Wages.
   d. Instructional Salary/Wages—From the Program Staff List, include the total Instructional Salary/Wages.
   e. Total Salary/Wages—Total of Administrative and Instructional Salary/Wages.

2. **Employee Benefits**—Enter the estimated costs for all fringe benefits.

3. **Professional Fees/Consultants**—Enter the total amount for all professional fees/consultants.

4. **Equipment/Furnishings**—Enter under the appropriate item (rental, repair and maintenance, or purchase/depreciation) the total projected expenses for each line item.

5. **Office Supplies**—Enter projected expenses.

6. **In-State Travel**—Enter total projected expenses for in-state travel. In the narrative state per mile and allowable expenses (based on organization travel policies).

7. **Occupancy/Rent/Utilities**—Enter total cost of occupancy.

8. **Current Expenses—**Enter projected expenses separately for telephone, postage, printing/reproduction, insurance, and food expenses (for WIDEP).

9. **Other**—Specify any other program expenses not previously noted above and include detailed explanation in the budget narrative.